Attachment A – Authorized Provider Services

ENROLLMENT
1915(c) HCBS NEW CHOICES WAIVER

Provider Name:_____

Effective Date:_____

FOR DHCF USE ONLY:

Provider #:

Category of Service:

PROVIDER is authorized to participate in the following waiver services (Mark all that apply):

(X)	New Choices Waiver Service	*FOR DHCF USE ONLY* MEDICAID PROVIDER TYPE
	ADULT DAY CARE	
	ADULT RESIDENTIAL SERVICES *	
	ASSISTIVE TECHNOLOGY DEVICES	
	ATTENDANT CARE SERVICES	
	CAREGIVER TRAINING	
	CASE MANAGEMENT *	
	CHORE SERVICES	
	CONSUMER PREPARATION SERVICES	
	ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	
	FINANCIAL MANAGEMENT SERVICES	
	HABILITATION	
	HOME DELIVERED MEALS	
	HOMEMAKER SERVICES	
	INSTITUTIONAL TRANSITION SERVICES	
	MEDICATION REMINDER SERVICES	
	NON-MEDICAL TRANSPORTATION	
	PERSONAL BUDGET ASSISTANCE	
	PERSONAL EMERGENCY RESPONSE SYSTEM	
	RESPITE	
	SPECIALIZED BEHAVIORAL HEALTH SERVICES	
	SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES	
	SUPPORTIVE MAINTENANCE (HOME HEALTH AIDE) SERVICES	

***** Attachment B, "Special Provisions Agreement", must be completed to become a provider for these waiver services.

Provider is available to provide services in the following counties:

(Please circle all that apply.)

Beaver County **Davis County** **Garfield County** **Iron County** **Kane County**

Morgan County **Salt Lake County** **Tooele County** **Washington County**

Weber County

The undersigned Provider Representative requests enrollment as a provider of Medicaid 1915(c) HCBS waiver services identified in this Attachment.

_____ _____

Signature of Provider Representative *Date*

The Division of Health Care Financing, Long Term Care Bureau, certifies that the above provider meets all qualifications listed in Appendix C-3 of the New Choices Waiver State Implementation Plan for the covered services authorized in this agreement and assures the contract provider is continuously certified / licensed throughout the period of the agreement. The undersigned Long Term Care Bureau Representative also certifies that the above designated category of service and provider type are accurate.

_____ _____

Signature of Representative *Date*
Division of Health Care Financing, Long Term Care Bureau